General Assembly

Raised Bill No. 5378

February Session, 2014

LCO No. **1740**

Referred to Committee on PROGRAM REVIEW AND INVESTIGATIONS

Introduced by:
(PRI)

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID-FUNDED EMERGENCY DEPARTMENT VISITS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-261m of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) The Commissioner of Social Services may contract with one or more administrative services organizations to provide care coordination, utilization management, disease management, customer service and review of grievances for recipients of assistance under Medicaid and HUSKY Plan, Parts A and B. Such organization may also provide network management, credentialing of providers, monitoring of copayments and premiums and other services as required by the commissioner. Subject to approval by applicable federal authority, the Department of Social Services shall utilize the contracted

organization's provider network and billing systems in the administration of the program. In order to implement the provisions of this section, the commissioner may establish rates of payment to providers of medical services under this section if the establishment of such rates is required to ensure that any contract entered into with an administrative services organization pursuant to this section is cost neutral to such providers in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality.

(b) Any contract entered into with an administrative services organization, pursuant to subsection (a) of this section, shall include a provision to reduce inappropriate use of hospital emergency department services, including a cost-sharing requirement. Such provision **[**may include**]** shall require intensive case management services **[**and a cost-sharing requirement.**]** including, but not limited to: (1) The identification by the administrative services organization of hospital emergency departments which may benefit from intensive case management based on the number of Medicaid clients who are frequent users of such emergency departments; (2) the creation of regional intensive case management teams to work with emergency department doctors to (A) identify Medicaid clients who would benefit from intensive case management, (B) create follow-up care plans for such Medicaid clients, (C) monitor clinical progress of such Medicaid clients, and (D) meet weekly with community providers treating such Medicaid clients; and (3) the assignment of at least one staff member from a regional intensive case management team to participating hospital emergency departments during hours when Medicaid clients who are frequent users visit the most and emergency department use is at its highest. For purposes of this section and sections 17a-476 and 17a-22f, as amended by this act, "frequent users" means a Medicaid client with ten or more annual visits to a hospital emergency department.

(c) The commissioner shall ensure that any contracts entered into with an administrative services organization include a provision

requiring such administrative services organization to (1) conduct assessments of primary care doctors and specialists to determine patient ease of access to services, including, but not limited to, the wait times for appointments and whether the provider is accepting new Medicaid clients, and (2) perform outreach to Medicaid clients to (A) inform them of the advantages of receiving care from a primary care provider, (B) help to connect such clients with primary care providers soon after they are enrolled in Medicaid, and (C) for frequent users of emergency departments, help to arrange visits by Medicaid clients with primary care providers not later than thirty days after such clients are treated at an emergency department.

(d) The Commissioner of Social Services shall require an administrative services organization with access to complete client claim adjudicated history to analyze and annually report, not later than February first, to the Department of Social Services and the Council on Medical Assistance Program Oversight, on Medicaid clients' use of hospital emergency departments. The report shall include, but not be limited to: (1) A breakdown of the number of unduplicated clients visiting an emergency department, and (2) for such clients with ten or more annual visits to any hospital, (A) the number of visits categorized into specific ranges as determined by the Department of Social Services, (B) the time and day of visit, (C) the reason for the visit, (D) whether hospital records indicate the client has a primary care provider, (E) whether the client had an appointment with a community provider not later than thirty days after the date of the hospital emergency department visit, and (F) the cost of the visit to the hospital and to the state Medicaid program. The Department of Social Services shall monitor its reporting requirements for administrative services organizations to ensure all contractually obligated reports, including any emergency department provider analysis reports, are completed and disseminated as required by contract.

(e) The Commissioner of Social Services shall use the report

required pursuant to subsection (d) of this section to monitor the performance of an administrative services organization. Performance measures monitored by the commissioner shall include, but not be limited to, whether the administrative services organization helps to arrange visits by Medicaid clients who are frequent users of emergency departments to primary care providers not later than thirty days after treatment at an emergency department.

Sec. 2. (NEW) (*Effective July 1, 2014*) Not later than January 1, 2015, the Commissioner of Social Services shall require that state-issued Medicaid benefits cards contain the name and contact information for a Medicaid client's primary care provider, if such client has chosen a primary care provider.

Sec. 3. Section 17a-476 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) Any general hospital, municipality or nonprofit organization in Connecticut may apply to the Department of Mental Health and Addiction Services for funds to establish, expand or maintain psychiatric or mental health services. The application for funds shall be submitted on forms provided by the Department of Mental Health and Addiction Services, and shall be accompanied by (1) a definition of the towns and areas to be served; (2) a plan by means of which the applicant proposes to coordinate its activities with those of other local agencies presently supplying mental health services or contributing in any way to the mental health of the area; (3) a description of the services to be provided, and the methods through which these services will be provided; and (4) indication of the methods that will be employed to effect a balance in the use of state and local resources so as to foster local initiative, responsibility and participation. In accordance with subdivision (4) of section 17a-480 and subdivisions (1) and (2) of subsection (a) of section 17a-484, the regional mental health board shall review each such application with the Department of Mental Health and Addiction Services and make recommendations to

the department with respect to each such application.

(b) Upon receipt of the application with the recommendations of the regional mental health board and approval by the Department of Mental Health and Addiction Services, the department shall grant such funds by way of a contract or grant-in-aid within the appropriation for any annual fiscal year. No funds authorized by this section shall be used for the construction or renovation of buildings.

(c) The Commissioner of Mental Health and Addiction Services shall require an administrative services organization with which it contracts to manage mental and behavioral health services to provide intensive case management. Such intensive case management shall include, but not be limited to: (1) The identification by the administrative services organization of hospital emergency departments which may benefit from intensive case management based on the number of Medicaid clients who are frequent users of such emergency departments; (2) the creation of regional intensive case management teams to work with emergency department doctors to (A) identify Medicaid clients who would benefit from intensive case management, (B) create follow-up care plans for such Medicaid clients, (C) monitor progress of such Medicaid clients, and (D) meet weekly with community providers treating such Medicaid clients; and (3) the assignment of at least one staff member from a regional intensive case management team to participating hospital emergency departments during hours when Medicaid clients who are frequent users visit the most and when emergency department use is at its highest.

[(c)**]** (d) The Commissioner of Mental Health and Addiction Services may adopt regulations, in accordance with the provisions of chapter 54, concerning minimum standards for eligibility to receive said state contracted funds and any grants-in-aid. Any such funds or grants-in-aid made by the Department of Mental Health and Addiction Services for psychiatric or mental health services shall be made directly to the agency submitting the application and providing such service or

services.

Sec. 4. Section 17a-22f of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) The Commissioner of Social Services may, with regard to the provision of behavioral health services provided pursuant to a state plan under Title XIX or Title XXI of the Social Security Act: (1) Contract with one or more administrative services organizations to provide clinical management, intensive case management, provider network development and other administrative services; (2) delegate responsibility to the Department of Children and Families for the clinical management portion of such administrative contract or contracts that pertain to HUSKY Plan Parts A and B, and other children, adolescents and families served by the Department of Children and Families; and (3) delegate responsibility to the Department of Mental Health and Addiction Services for the clinical management portion of such administrative contract or contracts that pertain to Medicaid recipients who are not enrolled in HUSKY Plan Part A.

(b) For purposes of this section, the term "clinical management" describes the process of evaluating and determining the appropriateness of the utilization of behavioral health services and providing assistance to clinicians or beneficiaries to ensure appropriate use of resources and may include, but is not limited to, authorization, concurrent and retrospective review, discharge review, quality management, provider certification and provider performance enhancement. The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall jointly develop clinical management policies and procedures. **[**The Department of Social Services may implement policies and procedures necessary to carry out the purposes of this section, including any necessary changes to existing behavioral health policies and

procedures concerning utilization management, while in the process of adopting such policies and procedures in regulation form, provided the Commissioner of Social Services publishes notice of intention to adopt the regulations in the Connecticut Law Journal within twenty days of implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are adopted.**]**

(c) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall require that administrative services organizations managing behavioral health services for Medicaid clients develop intensive case management that includes, but is not limited to: (1) The identification by the administrative services organization of hospital emergency departments which may benefit from intensive case management based on the number of Medicaid clients who are frequent users of such emergency departments; (2) the creation of regional intensive case management teams to work with emergency department doctors to (A) identify Medicaid clients who would benefit from intensive case management, (B) create follow-up care plans for such Medicaid clients, (C) monitor progress of such Medicaid clients, and (D) meet weekly with community providers treating such Medicaid clients; and (3) the assignment of at least one staff member from a regional intensive case management team to participating hospital emergency departments during hours when Medicaid clients who are frequent users visit the most and when emergency department use is at its highest.

(d) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall ensure that any contracts entered into with an administrative services organization require such organization to (1) conduct assessments of primary care doctors and specialists to determine patient ease of access to services, including, but not limited to, the wait times for appointments and whether the provider is accepting new Medicaid clients; and (2) perform outreach to Medicaid clients to (A) inform them of the

advantages of receiving care from a primary care provider, (B) help to connect such clients with primary care providers soon after they are enrolled in Medicaid, and (C) for frequent users of emergency departments, help to arrange visits by Medicaid clients with primary care providers not later than thirty days after such clients are treated at an emergency department.

(e) The Commissioners of Social Services, Children and Families and Mental Health and Addiction Services, in consultation with the Secretary of the Office of Policy and Management, shall ensure that all expenditures for intensive case management eligible for Medicaid reimbursement are submitted to the Centers for Medicare and Medicaid Services.

(f) The Department of Social Services may implement policies and procedures necessary to carry out the purposes of this section, including any necessary changes to procedures relating to the provision of behavioral health services and utilization management, while in the process of adopting such policies and procedures in regulation form, provided the Commissioner of Social Services publishes notice of intention to adopt the regulations in accordance with the provisions of section 17b-10 not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are adopted.

Sec. 5. Section 17b-241a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

Notwithstanding any provision of the general statutes, **[**and the regulations of Connecticut state agencies,**]** the Commissioner of Social Services may reimburse the Department of Mental Health and Addiction Services for targeted case management services that it provides to its target population, which, for purposes of this section, shall include individuals with severe and persistent psychiatric illness

and individuals with persistent substance dependence. The Commissioners of Social Services and Mental Health and Addiction Services, in consultation with the Secretary of the Office of Policy and Management, shall ensure that all expenditures for intensive case management eligible for Medicaid reimbursement are submitted to the Centers for Medicare and Medicaid Services.

Sec. 6. Section 17b-245c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) **[**(1)**]** As used in this section: **[**,**]**

(1) **[**"telemedicine"**]** "Telemedicine" means the use of interactive audio, interactive video or interactive data communication in the delivery of medical advice, diagnosis, care or treatment, and includes the types of services described in subsection (d) of section 20-9 and 42 CFR 410.78(a)(3). "Telemedicine" does not include the use of facsimile or audio-only telephone.

(2) "Telehealth" or "telemonitoring" means the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes such technologies as (A) telephones, (B) facsimile machines, (C) electronic mail systems, and (D) remote patient monitoring devices used to collect and transmit patient data for monitoring and interpretation.

[(2)**]** (3) "Clinically appropriate" means care that is (A) provided in a timely manner and meets professionally recognized standards of acceptable medical care, **[**;**]** (B) delivered in the appropriate medical setting, **[**;**]** and (C) the least costly of multiple, equally effective alternative treatments or diagnostic modalities.

(b) **[**The**]** Not later than January 1, 2015, the Commissioner of Social Services **[**may**]** shall establish a demonstration project to offer telemedicine, telehealth or both as **[**a**]** Medicaid-covered **[**service**]**

services at federally qualified community health centers. Under the demonstration project, in-person contact between a health care provider and a patient shall not be required for health care services delivered by telemedicine or telehealth that otherwise would be eligible for reimbursement under the state Medicaid plan program, to the extent permitted by federal law and where deemed clinically appropriate.

(c) The Commissioner of Social Services may establish rates for cost reimbursement for telemedicine and telehealth services provided to Medicaid recipients under the demonstration project. The commissioner shall consider, to the extent applicable, reductions in travel costs by health care providers and patients to deliver or to access health care services and such other factors as the Commissioner of Social Services deems relevant.

(d) The Commissioner of Social Services may apply, if necessary, to the federal government for an amendment to the state Medicaid plan to establish the demonstration project.

(e) The transmission, storage and dissemination of data and records related to telemedicine and telehealth services provided under the demonstration project shall be in accordance with federal and state law and regulations concerning the privacy, security, confidentiality and safeguarding of individually identifiable information.

(f) **[**The**]** Not later than July 1, 2015, the commissioner shall submit a report, in accordance with section 11-4a, on any demonstration project established pursuant to this section to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services. The report shall concern the services offered**,** **[**and**]** the cost-effectiveness of the program and whether it should be extended to other areas of the state.

Sec. 7. Section 17b-292 of the general statutes is amended by adding subsection (m) as follows (*Effective July 1, 2014*):

(NEW) (m) A child who has been determined to be eligible for benefits under either the HUSKY Plan, Part A or Part B shall remain eligible for such plan for a period of not less than twelve months from such child's determination of eligibility unless the child attains the age of nineteen or is no longer a resident of the state.

Sec. 8. Subsection (f) of section 17b-261 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(f) To the extent permitted by federal law, Medicaid eligibility shall be extended for one year to a family that becomes ineligible for medical assistance under Section 1931 of the Social Security Act due to income from employment by one of its members who is a caretaker relative or due to receipt of child support income. A family receiving extended benefits on July 1, 2005, shall receive the balance of such extended benefits, provided no such family shall receive more than twelve additional months of such benefits. On and after July 1, 2014, the Commissioner of Social Services shall seek federal approval for a continuous eligibility period of twelve months for an adult who has been determined eligible for the Medicaid program. Pursuant to the provisions of section 17b-8, the commissioner may amend an existing Medicaid waiver program or apply for a new Medicaid waiver, as necessary, to implement the provisions of this section.

Sec. 9. Section 17b-261c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

In no event shall an individual eligible for medical assistance under section 17b-261, as amended by this act, be guaranteed eligibility for such assistance for **[**six**]** more than twelve consecutive months without regard to changes in certain circumstances that would otherwise cause the individual to become ineligible for assistance.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2014*	17b-261m
Sec. 2	*July 1, 2014*	New section
Sec. 3	*July 1, 2014*	17a-476
Sec. 4	*July 1, 2014*	17a-22f
Sec. 5	*July 1, 2014*	17b-241a
Sec. 6	*July 1, 2014*	17b-245c
Sec. 7	*July 1, 2014*	17b-292
Sec. 8	*July 1, 2014*	17b-261(f)
Sec. 9	*July 1, 2014*	17b-261c

Statement of Purpose:

To implement the recommendations of the Program Review and Investigations Committee concerning averting unnecessary use of hospital emergency departments by Medicaid clients.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]